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AIDS Virus
AIDS Patient

BG MAGAZINE

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IN THIS ISSUE
AIDS: The Crisis Continues

Editorial 3

13 Vulnerable Spots In Virus Life Cycle by Gina Kolata 5

African-American Men and HIV Antibody Testing by Vickie Mays, Ph.D. Susan Cochran, Ph.D. 7

Exercise: A Key to Preventive Medicine by M. Mike Wade 9

The Truth In Knowing: Taking the Test by Gary Paul Wright 10

Annnual Fall Survey 9
A Word On Plays:
by E.K. Washington
Once On This Island 12
FALSETTOLAND 17

Managing Your Doctor by Michelle Roland 19
Treatment Information by Tony Davis 23

COVER

AIDS: The Crisis Continues.
Cover Illustration by John Labbe

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EDITORIAL

ACT-RIGHT (ak-rite)

Almost ten years have past since news of a mysterious gay cancer was reported. And although it is no longer a mystery nor exclusively gay. There is still no cure for Acquired Immune Deficiency Syndrome. To date it has claimed the lives of tens of thousands in the U.S. alone. Around the world more than 3000 cases of AIDS are reported every month. Twenty-five percent of all persons with AIDS in the United States are African-American. Among the newly diagnosed, the figure exceeds 37 percent. Black and Latina sisters account for almost 85 percent of all adult female AIDS cases in New York City.

Ours is an unusual dilemma. As coined by Harlon L. Dalton, Associate Professor of Law at Yale Law School, "AIDS in Blackface" (DAEDALUS, Spring 1990) has a number of complicated components. Our community for a number of reasons have not "owned" AIDS; the first step toward an honest effort to stop the disease in our community.

The first reason is perhaps our initial confusion about who the disease affected. Our first impressions were that this was a "white gay mens" disease. It has been only recently that we have learned of the devastation it has been responsible for in our community. Thanks only to those who were the most vocal at the time. And who knows, if that segment of the gay community was not as vocal at that time, how far the disease would have been allowed to progress in all segments of our society? (We must applaud the work of ACT-UP, GMHC etc..for their early efforts).

Nonetheless, we at the time, had no reason to think, as per the media, that we were the most vulnerable. In part, we needed to make sure that we did not receive "blame": Perhaps, the second reason for our inaction in this crisis. Dalton notes that "so long as we..continue to worry that any hint of connection with AIDS will be turned against us, we will remain leery of accepting responsibility for its impact on our community."

Our failure to accept this disease early on may be because we fear, in fact, another reason to bare the brunt of society's hate. To be black, male, gay and HIV positive might just be psychologically too much to bare.

It comes as no surprise to me also that our own homophobia allows us to jeopardize our lives. The fact that we may be much more willing to accept the drug relatedness of our HIV infected brothers and sisters as the "only" cause for their infection, points out our unwillingness to even recognize homosexuality in our community. Finally (And I believe this is our most basic of problems) Dalton notes that in our community "it is all right if everybody knows as long as nobody tells." Our need to be accepted is prompted by our need to survive. It should not come as a surprise that in a society where people willingly admit, and perceive, that black women pose no threat but black men are considered as such, we should cling to our family, to be accepted by someone (closeted), what ever the cost. Rejection in our own community leaves us, really, no where to turn.

If you won't ACT-UP,
Then it is time to
ACT-RIGHT (ak-rite)

It is not necessarily true that we must turn away from that community to fight this disease. What is true is that we must arm ourselves with the knowledge made available in this issue and other publications like it to survive. We must ACT-RIGHT!

ACT-RIGHT means taking the test now to give ourselves a fighting chance. ACT-RIGHT means that we pass this issue on so that all of us can ACT-RIGHT with the weapon of Knowledge. ACT-RIGHT means we use safer sex to ensure that our brothers and sisters don't get this terrible disease. And finally ACT-RIGHT means that we all in our own individual way become V.O.C.A.L! (Voices Of Color against AIDS and for Life).

THE CITY OF NEW YORK
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A total of 143,286 AIDS cases have been diagnosed among adults and adolescents in the United States; New York City accounts for one-fifth of this total. AIDS is the leading cause of death among New Yorkers between the ages of 25-44 and 1-4. African-American and Latinos account for approximately 61% of the New York's adult cases and over 90% of pediatric cases. It is currently projected that as many as 235,000 New Yorkers may be infected with HIV. Clearly AIDS is the worst public health disaster our city has faced in this century.

This epidemic has ravaged the gay and lesbian community and is increasingly becoming a number one health concern for women, children and people of color. The reality of HIV illness demands that health care providers, policy makers and activists, from all communities, recognize the connections between AIDS and poverty, lack of access to quality health care and housing, and the impact of racism, sexism and homophobia. The problems are clear, but what are the solutions?

Shifting Resources

Our communities must continue to challenge the legislatures to fund AIDS programs. However, as dollars shrink, we will have to responsibly prioritized expenditures.

Community Based Services

Community based organizations are the experts on the front lines. Though culturally relevant and linguistically sensitive approaches, both primary care and prevention are more expedient. CBO's like GMHC, Minority Task Force on AIDS and others are our life-line. They must be supported by the government, by community organizations and by individual volunteers.

Education

Knowledge and information are still the best weapon against HIV. Schools, churches, health care providers and community organizers need to spread the message of education and prevention to all.

Counseling/HIV-Testing/Referral

Psychological and social interventions are an integral part of successful medical treatment. Anonymous and confidential testing must be available in conjunction with appropriate referral sources. Significant others and families need to have access to quality psychological services.

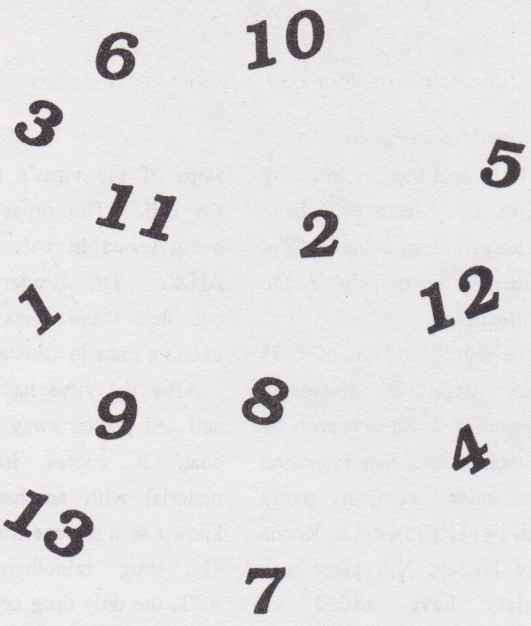
Our office is actively engaged in challenging city agencies (Department of Health, Health and Hospitals Corp., Department of Mental Health) to make AIDS a priority. We continue to work closely with the Human Rights Commission's AIDS Discrimination Unit. Our AIDS Advisory Council provides us with monthly updates on AIDS programs in NYC.

Silence does in fact equal death. We must continue to support every effort that has a chance of being successful in treating and providing services to people with AIDS. We must promote education and prevention and we must challenge the mythology of "risk" groups; until there is a cure.....

AIDS Research Finds 13 Vulnerable Spots In Virus Life Cycle

Advances bring optimism about future therapies.

by Gina Kolata
The New York Times



Molecular biologists and drug development experts have climbed rapidly from a valley of despair to a peak of expectation in their struggle to combat the AIDS virus. The formidable virus once seemed almost beyond the reach of chemicals or vaccines. But biologists are now confident they have identified 13 major chinks in its armor, each one of which may in time yield to therapeutic attack.

They expect that even if no cure is developed, AIDS will in time cease to be lethal or even infectious, becoming instead a manageable disease, even if one that may require lifetime medicine. However, this goal may not be reached for 10 to 20 years, says Dr. William Haseltine of the Dana Farber Cancer Institute at Harvard.

When the AIDS virus was discovered in 1984, researchers were deeply pessimistic about ever finding a treatment. There were very few drugs that could stop viral infections, and the AIDS virus was a different type of virus than any that had been treated before. It was a retrovirus, a virus that places a copy of its genetic material inside the cell's DNA, where it can hide from any pharmaceutical attack.

Researchers and drug companies doubted it was worthwhile to go after the virus. And even when Dr. Samuel Broder, director of the National Cancer Institute, found that AZT debilitated the virus in the test tube, he encountered strong resistance from the scientific community and from drug companies in his quest to test the drug in patients.

Yet since the discovery of the virus, new knowledge about its life cycle and chemistry has accumulated at a brisk pace. "We have learned more about the AIDS virus than any other virus that affects humans," Dr. Haseltine said. Only poliovirus has been studied in similar detail, and that knowledge was the cumulation of 40 years of research. The AIDS virus research has been compressed into six years since the virus was discovered, Dr. Haseltine notes.

In an article published in the current Science Magazine, Dr. Broder and his colleagues Dr. Hiroaki Mitsuya and Dr. Robert Yarchoan, describe the minutely detailed picture that has been developed of how the AIDS virus enters cells and reproduces. This picture suggests many ways in which the virus can be stopped.

"What the article shows is a factual basis for saying that I'm optimistic," Dr. Broder said. "There really is a large and growing menu" of ways to stop the virus, he explained. "I think it's a very important time."

Other experts share his optimism. "We hope to extend forever the period when the virus is latent," said Dr. Jeffrey Laurence, an AIDS researcher at Cornell University School of Medicine in New York. "The virus will be sitting there in T cells, but it will not be much of a problem," he explained. And with little free virus outside these disease-fighting immune cells, the infection should be much more difficult to transmit, Dr. Laurence added.

Dr. John McGowan, who directs a joint program between the Division of AIDS at the National Institutes of Health and a group of drug companies, said that the program has identified promising compounds that stop the virus at several crucial points in its life cycle.

In their Science paper, Dr. Broder and colleagues cite how molecular biologists have now identified 13 distinct steps in which the virus replicates itself. Drugs have already been devised that can interrupt many of these steps in test tube experiments.

The first step in infection is for the AIDS virus to attach itself to a protein, CD4, which the cells of the human immune system wear on their surface. In the test tube, the attachment process can be blocked by decoy chemicals that stick to the virus and by drugs that stick to the CD4 proteins.

The CD4 surface protein can be made by generally programmed bacteria. Tests

(Continued from page 5)

using CD4 as a therapy to decoy the virus away from cells have been disappointing because CD4 is destroyed so quickly in the bloodstream.

But a modified form of CD4 may last longer, Dr. McGowan said, pointing to an approach by Genentech Inc., a San Francisco pharmaceuticals company partly owned by Hoffmann-La Roche Inc. of Nutley, N.J. Genentech scientists have added an antibody to CD4 to prevent it from being broken down, by making the protein invulnerable to enzymes that chop it up. But the cost of the drug, the fact that it has to be injected and its less-than-promising clinical results in early studies may limit its use.

The next step in the virus's life cycle, however, is seen by experts like Dr. Broder an Dr. McGowan as an extremely promising target for novel AIDS drugs. In this step, the virus, having entered a cell, uses one of its own products to knock a hole in the proteins that coat it. The product, an enzyme that breaks down proteins, is used again later, when proliferating viruses are ready to break out from an infected cell. In the final step of the virus life cycle, the enzyme is used to cut long virus proteins into shorter lengths for its coat, "like a sawmill that turns rough timber into lumber," Dr. McGowan said.

Several companies have developed drugs that interfere with this enzyme. In the test tube, the drugs successfully block both the first and final steps of the virus's life inside the cell. The drugs are now being tested in volunteers with AIDS. Dr. Broder said he considers these drugs the most exciting ones in clinical studies.

After the virus has entered a cell and peeled away its protein coat, it copies its genetic material with another enzyme, known as a reverse transcriptase. The drug azidothymidine, or AZT, the only drug approved for the treatment of AIDS, works by inhibiting this enzyme, as do several other drugs that are undergoing clinical testing. Each of these drugs seems to have different side effects, so researchers expect they will be able to combine or alternate the drugs so as to minimize the side effects of each.

In the next step of its life cycle, the virus inserts copies of its own genetic material into the cell's DNA. There it remains, inactive, inactive, until the cell is stimulated by any of several triggers, including other viruses and immune system hormones. At this signal, the virus starts to replicate itself. Dr. McGowan's group and Hoffman-La Roche have developed three drugs that show promise in preventing the inactive virus from starting to replicate.

"It's very exciting," Dr. McGowan said. He compared turning on the virus to "turning on a light switch," adding that with drugs that keep the switch in an off position "you may be able to keep the virus dormant."

Other new drugs attack at two other steps in the life cycle. The

(Continued on page 22)

AIDS Resource Center Inc.

The AIDS Resource Center is a nonprofit organization providing housing, support services and pastoral care to homeless men, women and families with AIDS. Housing is offered through Bailey House, a group residence for 44 adults, and the Supportive Housing Apartment Program, now expanded to 40 apartments serving families, couples and individuals with AIDS. Pastoral care and spiritual counseling is available citywide for people of all faiths.

CONTACT NAMES AND NUMBERS

Housing/Supportive Housing Apartments
Rae Ann Santana 481-1270
Tom Rini 481-1270

Housing/Bailey House
Elinor Polansky 337-3058

Interfaith Pastoral Care
Rev. Karen Ziegler 481-1270

Donations/Supportive Housing Apartments
Michael Borden 481-1270

Donations/Bailey House
Gordon Hough 337-3011
Peggy Scherer 337-3050

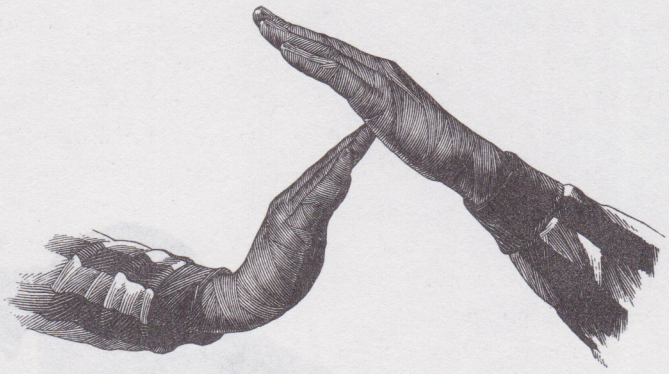
Volunteers
Joan McElroy 481-1270

A copy of our latest financial report is available by writing the New York State Office of Charities Registration, 162 Washington Avenue, Albany, NY 12231.

AFRICAN-AMERICAN MEN AND HIV ANTIBODY TESTING

by Vickie M. Mays, Ph.D.
Susan D. Cochran, Ph.D.

Black C.A.R.E. Project



In 1981 when a mysterious disease began to appear, later identified as a deadly viral infection, all eyes and resources focused on White gay men. They were young and they were dying long before their time. Newspapers, television and even the gay press bombarded us with the news of their tragedies as these young men succumbed to a new disease. Many African-American watched from the sidelines as the "gay white disease" progressed. For many, the watching was accompanied by a false sense of security that this disease was something that happened to "White boys" and if you didn't have sex with them you wouldn't catch it. But as the months passed with increasing numbers of White gay men infected, this perception of invincibility, too, vanished as friends, lovers and other African-Americans in pour community were increasingly affected by the disease. African-American gay men realized that they could get AIDS.

Yet, there did not seem to be the same focus or concern for these men as seen in the White community. Research efforts were directed toward understanding AIDS among gay men, but African-American men were underrepresented participants in this research. So even in 1990 there are so many questions in the HIV disease spectrum where the experiences of African-American men are not well know. It is only recently that researchers are able to tell us something about how African-American gay men are responding to AIDS. One such question is the psychological effects of early detection of viral infection.

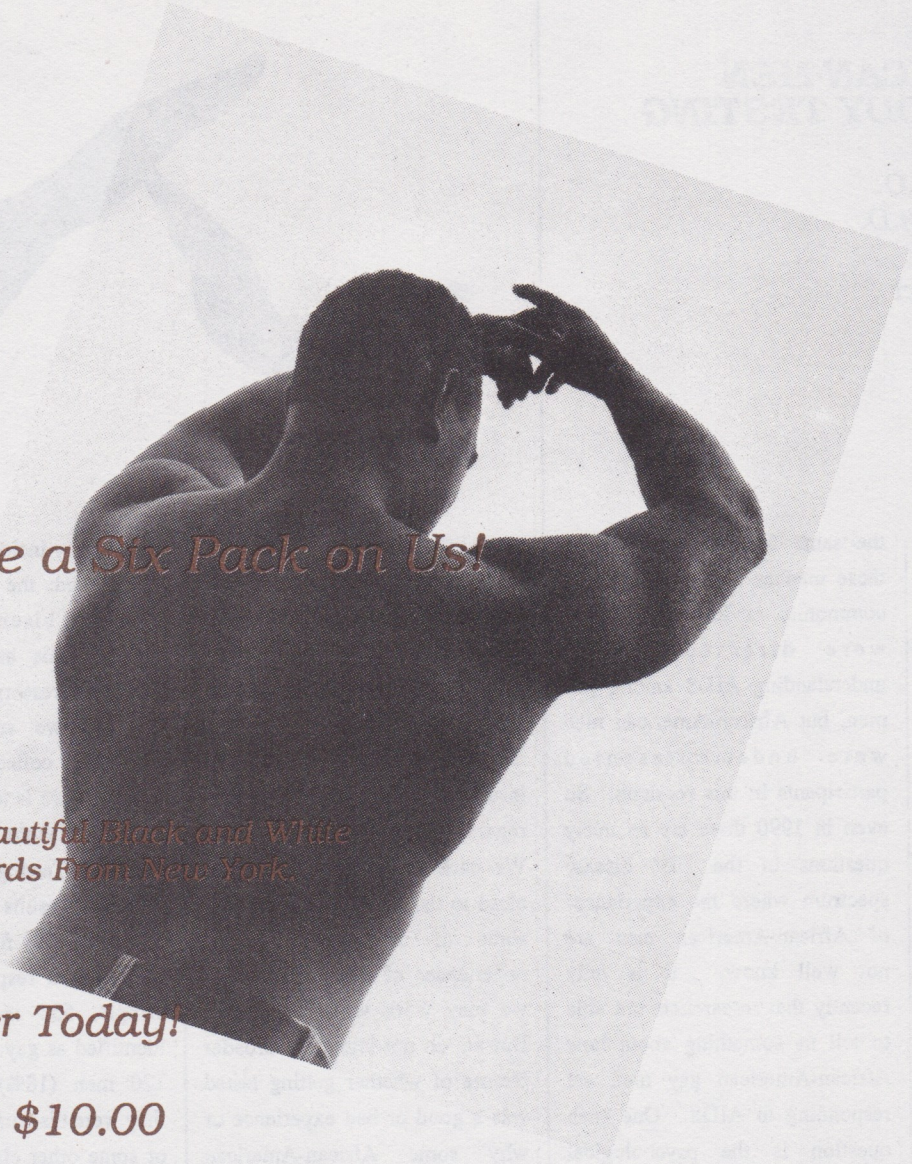
Getting tested is not a simple act. Rather it is something that can have at minimum legal, financial, medical and emotional consequences. While advocated for the sake of early medical treatment, for some, horrendous stories often played up in the media of suicides, evictions, loss of health insurance, abandonment by lovers and families make the decision a very difficult one.

Yet we know very little about the decision-making of Black gay and bisexual men as a group regarding HIV antibody testing. We each know stories of those close to us, or of Black gay and bisexual men as a group regarding HIV antibody testing. We each know stories of those close to us, or of ourselves. For some of us, we know the experiences of many others that we may work with or counsel. But we do not know the broader picture of whether getting tested was a good or bad experience or why some African-American men have not gotten tested.

As part of an effort to document the experience of the diverse community of African-American gay and bisexual men and men who have had sex with other men but do not necessarily identify as being gay, Black C.A.R.E. has been conducting a national study of psychological response to the threat of AIDS. We have been collecting data from all segments of the African-American men's community including those often overlooked: the incarcerated in prison, bisexually active heterosexuals and transpersons and crossdressors.

While we are still in the process of collecting that data, our aim here is to share some to the early results regarding HIV Antibody Testing. We currently have the results from our first 658 men ready for a preliminary look at their responses. Of this sample, 538 men (82%) self identified as gay. An additional 120 men (18%) reported that they were bisexual, heterosexual, or some other classification. In order to take a quick look at the results we classified the men as either gay or non-gay identified.

A first question was whether Black gay or non-gay identified men get tested. For both groups approximately 65% had been tested. Recognizing the possibility of a strong emotional response to testing, we asked the men whether they felt that knowing their test results have helped, hurt or had no effects on them. Looking back at their



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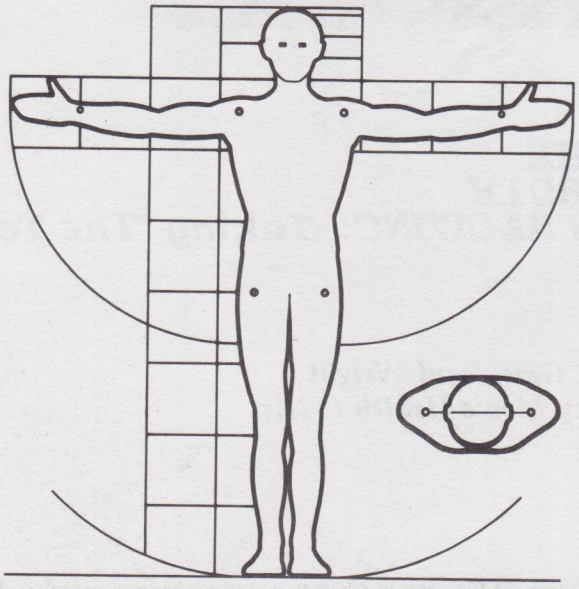
Exercise; A Key to Preventive Medicine

by M. Mike Wade
Body Maintenance



Time and again you have heard about the benefits of exercise. Why? Exercise is one of the best kept secrets in preventive medicine. Medical studies performed by the American College of Sports Medicine have provided proof that exercise has intrinsic benefits that go beyond strength and physical appearance. People who engage in regular exercise tend to have lower levels of stress than those who do not exercise, and generally feel good about themselves. Medical experts have found that our immune systems are directly connected to our state of mind. Healthy mind, healthy body. Thus the evolution of psychoneuroimmunology. A discipline that studies the healing powers of the mind.

So, what about exercise and the HIV virus? Exercise is a great defense against illness. Studies have proved that exercise builds our resistance todegenrative diseases. Ones immune system is assisted by the improvement of blood circulation brought about by exercise. This increase in circulation hastens the removal of toxins from the blood, aids digestion and elimination and calms the nerves. Most importantly, exercise leaves one with an extraordinary sense of well being which in turn blocks the despair and depression that hamper the immune system in fighting off disease.

One being diagnosed HIV positive people usually undergo major changes in lifestyle. Exercise can be a part of those changes, for asymptomatic persons as well as those who are symptomatic. Asymptomatic persons may involve themselves in a wide range of exercise, from low-impact aerobics to bodybuilding. Symptomatic persons are advised to engage in low keyed exercises such as brisk walking, low impact aerobics or light weight lifting for improved strength and muscle tone.

Exercise can be broken down into four basic types: cardiovascular, circuit, strength, and bodybuilding training.

Cardiovascular exercises involves the use of a lifecycle, rowing machine, treadmill or stairmaster, as well as engaging in other types of aerobic exercise (dance, running, etc..) The emphasis in this type of exercise is placed on improved cardiovascular shape (improvement of bodily functions such as circulation, digestion, etc..) and maximum weight loss. A minimal amount of body toning is also achieved. When using aerobic machines, cardiovascular exercise is done at varied resistances. The exercise should be performed from twenty minutes to an hour and at least three times per week.

The second type of exercise, circuit training, is perfect for those with tight schedules. Circuit training involves ten to fifteen weight machines designed to exercise every muscle group in the body. The machines designed to exercise every muscle group in the body. The machines are placed in a row or circle and the exerciser moves from one machine to the next, completing one set of exercise on each machine. A moderate amount of weight is used (about 50% of maximum) and a high number of repettions are done (12-15). The repetitions should be completed within thirty seconds, followed by a thirty second rest period before beginning on the next machine. Most health clubs that offer circuit training have a continuously running taped voice that instructs the exercisers when to begin, stop and move to the next machine. Circuit training offers moderate muscle toning and weight loss since it is aerobic in nature yet includes resistance exercise. The circuit should be completed one to three times depending on the exercisers level of conditioning.

Strength training is used to develop a moderate to maximum amount of muscle strength and development. Moderate to heavy weights are incorporated (75-90% of max.) with a low number of repetitions (6-8), multiple sets are done of each exercise with one to two minutes rest between each set. A three to six day rotation routine may be utilized to work different bodyparts separatly on different days. This allows each bodypart at least twentyfour hours to recouperate and minimizes the length of each training session and energy expenditure. For example, on Monday the chest, biceps, calves and abdominals are

THE TRUTH IN KNOWING: Taking "The Test"

By Gary Paul Wright
Gay Men's Health Crisis

It took me five years to decide to take the HIV antibody test. For one thing, I simply assumed that given my wild sexual days of being young, Black, and skinny and living in Hollywood, I just HAD to be positive.. So why take the test? I'd been exposed to everything else, all the popular maladies of the seventies-syphilis,gonorrhea,hepatitis B. I was a card-carrying member of at least three popular bath housed, had encounters in the bushes of Griffith Park, and gladly participated in backroom orgies sf several LA hot spots. Needless yo say, when rumors of the "gay cancer" began to circulate, I assumed I was in deep shit. Added to that was the fact that only white boys were getting sick and I had my share of them.. Although no one I'd slept with actually came down with what was then upgraded to "GRID" (gay-related immune deficiency), my friends who only "slept Black" seemed not to be too worried.

Around this time , the early eighties, I entered into my first real monogamous relationship. His name was Bob. Though talk of condom usage became popular in Los Angeles, it was more talk than usage. Bob and I were healthy, and since for all intents and purposes we were married, the thought of using condoms seemed silly. Our sex life was intense. We weren't into (what we considered) kinky stuff like scat or fisting or water sports, But some of the things we were into would now be considered unsafe. For instance, the thought of pulling out before cumming never occurred to us.

For years we were a model couple. Primarily our friends were other gay couples and we would all do the movies, parties and brunches together--very, very California. We all Knew about AIDS, yet none of us had been touched by it. It only happened to hustlers and sluts, certainly not to progressive gay men like ourselves. But by 1984, things began to happen. For the first time, someone close to me was diagnosed with AIDS. His name was Herb. He was about 28 years old, a practicing Christian, and, for all I knew, faithful to his lover of many years. How he came to be infected I'll never know. It didn't matter. Herb died about seven months after his diagnosis.

In May of 1985, I left Los Angeles and moved to New York. I became a "warrior" in the fight against AIDS as a volunteer for Gay Men's Health Crisis. I began facilitating workshops on safer sex and the where-and-how-to's of meeting men. Often questions concerning "The Test" would come up and I found myself explaining that as a volunteer, I could only parrot what GMHC had to say on the subject. Moreover, it was up to the workshop participants to make their own informed choices. Later, when GMHC came out with their more neutral policy statement, the matter became to me one of solidarity. I was personally against testing because people of color still did not have access to the proper medical care, prophylaxis treatments or, for that matter, insurance as suggested by GMHC to their target audience.

I wondered from time to time if I was making the right informed choice for myself. I still held fast to the assumption that I was probably HIV positive, and that mu sexual partners were positive as well. At least I treated them that way. I figured it was better to be safer than sorry, and since safer sex seemed to be the norm, I had no problem convincing myself that as long as I was protecting myself, I was protecting my partners as well.

It became evident that the luxury of my assumptions was lost to me when the issues involved came to a head. During one night of serious lovemaking, my partner stopped in the middle of our rapture to take his AZT capsule. When he came back to bed I not only lost my hard-on, but I'd lost interest in continuing our copulation. I feigned tiredness and rolled over to sleep, In reality, O was awake for quite some time. Why was I so bothered?

The scenario became even more complicated the next day when the amour du jour informed me that within six weeks he would be entering a major hospital to undergo an experimental bone marrow transplant. It would require chemotherapy, radiation,

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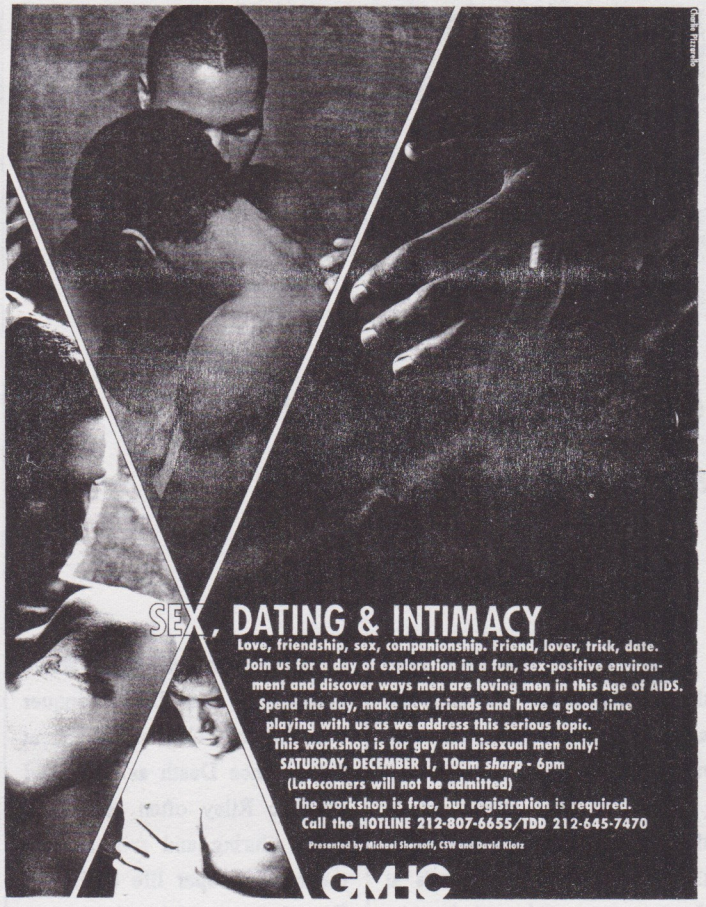

THINK ABOUT IT:

Deciding to take the test.

Are you thinking of taking the HIV antibody test (the "AIDS test")? Do you have the knowledge, decision making skills and support that you need to make an informed choice for yourself about whether or not to take the test? This new workshop will give you the information you need and can help you work out the many issues involved in this important decision.

Among the topics covered are: medical, psychological and social advantages and disadvantages of testing, dealing with your test results, maintaining safer sex, dealing with sexual partners/lovers, family and more.

The workshop is open to all, male and female, gay and non-gay.

Saturday, December 8, 1-6 pm
The Center, 208 West 13th Street, Third Floor
Registration is required. Call the HOTLINE:
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ONCE ON THIS ISLAND

by E.K. Washington

Can Love conquer even death? Apparently the gods are as innocent as children on these matters.

Once On This Island, as its title cues, is a tale. The rage of thunder, lightning and winds at the onset are pierced by the squall of a little girl terrified by the storm. This prompts the adults to recount a story in order to quell her fright, the story of a peasant girl named Ti Moune (La Chanze) who, once on this island, prayed to the gods to be carried away by a grand homme. Poor black peasants and wealthy mulatto grands hommes "with their French ways" comprise the unequally divided populace of this island that is sometimes called Jewel of the Antilles.

But gods are in local abundance here too, and this story is principally dispatched by four in particular who drive the tale as sleekly, through narrative and song, as a sports car careening along a treacherous mountain highroad. The gods decide to fulfill Ti Moune's prayer, doing so in order to satisfy their intrigue to the above question: Can Love conquer even Death? One hopes not, at times, since Death as embodied by Eric Riley often seems far more alluring and sensual than the rather proper life of Daniel Beauxhomme (played by a convincingly aristocratic Jerry Dixon), son of the cafe creme-skinned elite whom the peasant girl rescues from his crashed car during a violent storm. While futilely attempting to nurse him back to life, Papa Ge, Demon of Death arrives to claim the boy, at which point Ti Moune strikes a deal to stake her own life to have Daniel's spared. Miraculously Daniel heals and Ti Moune becomes his lover.

....Death as embodied by Eric Riley often seems far more alluring and sensual...

Rest assured that life does not go on entirely happily ever after.

"Some girls you marry, some you love"

Ti Moune's people regard her marriage prospects with 'fat chance' incredulity; the Beauxhomme household resolutely reminds their son of his place. Inevitably, Ti Moune finds herself thrown over for another, Andrea (Nikki Rene), who's ben promised to Daniel since childhood as her beau explains that "some girls you marry, some you love." Papa Ge, in his nefarious generosity, does give Ti Moune an opportunity to save her skin (which he has come to collect). "Kill him," he instigates, offering her a knife to use against the boy who betrothed, then betrayed, her. "Kill the love you feel."

The performances of the 11-member cast are winning on all counts although special mention should be given to the deities Erzulie, Goddess of Love (played by Andrea Frierson; Agwe, God of Water (Milton Craig Nealy); Asaka, Mother of the Earth (Kecia Lewis-Evans). The show's book and lyrics are by Lynn Ahrens set to a score by Stephen Flaherty. Based upon the novel My Love, My Love by the Trinidad-born author Rosa Guy, it has all the opulence of color, music and sun-ripened smiles that one would expect of a Caribbean folk fable. The set, costume and lighting designs by Loy Arcenas, Judy Dearing and Allen Lee Hughes, respectively, evoke the mystical lushness and vibrancy of Haitian primitive art. Under Graciela Daniele's choreography and direction, all elements of this production are swirled into a most satisfying and ebullient elixir. It's a show sweet as cane, though its optimism doesn't give you a toothache.

Questionnaire

In our new magazine format, BG is now reaching many more readers than before, and we would like to get to know you better. Please fill out this questionnaire and return it (fold it so that the postage and address appears outside). We'll keep all information strictly confidential. The first two hundred people to respond will receive a free subscription to BG Magazine.

1. How old are you?
__ Under 18 __ 18-20 __ 21-24 __ 25-29 ___ 30-34 __ 50 or Over

2. What is your sex? __ Male __ Female

3. What is your current employment status?
__ Employed full time (30 or more hours a week)
__ Employed part time __ Not currently employed

4. If you are employed, what is your occupation?
Position_____
Type of business_____

5. Please indicate your yearly salary.

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___ $25,000 to $39,999 ___ $40,000 to $49,999
___ $50,000 to $59,999 If more than $59,999, please enter approximate amount $_____

6. What is the highest level you completed in school?

___ Some high school ___ High school graduate ___ Attended college less than 1 year
___ Attended college 1-3 years ___ Graduated from college ___ Postgraduate study or degree

7. Are you currently attending a college or university?

___ Yes, full time ___ Yes, part time ___ No School name_____

8. With whom do you live? ___ Alone ___ With parents/relatives ___ With roommate(s)

9. What is your total household income before taxes? Please include income for yourself and all other persons living in your household from all sources including wages, bonuses, dividends, rental income, trust funds, interest on savings, grants etc.
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11. Is this the first issue of BG Magazine that you have read?___ Yes ____ No

12. If no, when did you begin reading BG?_____

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15. How many of your friends or members of your household have read or looked through this issue of BG Magazine?_____

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transfusions, IV AZT and more. The man would be going through hell to rid his body of HIV.

Several issues came to mind. First, in my mind having sex with someone makes that person a potential lover. Now that this person had disclosed his HIV status, does this mean I may possibly become a "care partner?" If he is taking AZT now, will we soon have to learn to clean a catheter? Secondly, if we are both HIV positive what are our chances of reinfecting each other no matter how "safe" we are? Does this continuum of risk of risk become any different?

I have lost too many friends to this disease to sit back and watch another person go while I lick my wounds. The fight must continue. The first step in my new resolve was to arm myself. I wanted to find out as much as I could about my own health in order to take proactive steps to my survival. It meant finding our just what my immunostatus was. It meant I had to take "The Test". My doctor suggested waiting for T-cell counts until we found out what my HIV status was. When I told him that I had assumed over the last few years that I was positive, he wasn't impressed.

The two week wait for my results was nerve-wrecking. I didn't sleep well and my waking hours were very tense. It was two weeks of hell! By the time I arrived at my doctor's office, my underarms were dripping cold sweat. I just wanted to get the whole, ugly routine over with. I knew what the answer would be, and I didn't feel the need for formality. Just show me the damn paper and let me get on with it.

When the word N-E-G-A-T-I-V-E rolled off the doctor's lips, my own mouth fell to the floor. The next few moments went by in slow motion as I asked him to repeat it. Then he showed me the printed words:"Negative for antibody to HIV-1". If I recall correctly the next words out of my mouth were THANK YOU JESUS! and a smile appeared across my face as big as the state of Texas. I hugged the doctor, thanked him, hugged the receptionist, thanked him and walked out into the sunlight feeling like a million bucks.

When I made it home, I realized what a fool I'd been for the past five years. I was just waiting around to get ill. Not taking a proactive stance with my own health was tantamount to suicide. Even if my assumptions had been true, why had I not monitored my immune system? Was it because I didn't want to take back the responsibility of my own health that I thought was taken away from me? Did the fact that I practiced safer sex make it alright enough for me to live with my assumptions?

I can only blame myself, as an educated Black man, for not taking charge of my life. Political correctness cannot necessarily keep one healthy. There are social systems available to me. I do have access to healthcare, that is my right, not just a privilege. And no one can access these systems for me if I don't avail myself to them. Too many of my brothers wait until it is too late to get proper care, one of the reasons Black men die at five times the rate of their white counterparts. Although it is true that there are social constructs in place that make life harder for us , we can't sit back until we are all dying to start blaming someone else. Then it will be too late.

I have been given my life back to me. I will continue to have sex and will do it safely. My blood will be tested every six months and my immune system will be monitored. If and when Mr. Right comes along I will insist that he do the same because now that I know I have something to protect, I surely will protect it. So if you just happen to be that Mr. right and you're reading this, please know that I still remember what I learned back in sixth grade: and in the words of Sister Mary Kenneth, "never, never assume". When it comes to our love, our sex, and our health, don't make an "ASS" out of "U" and "ME"!

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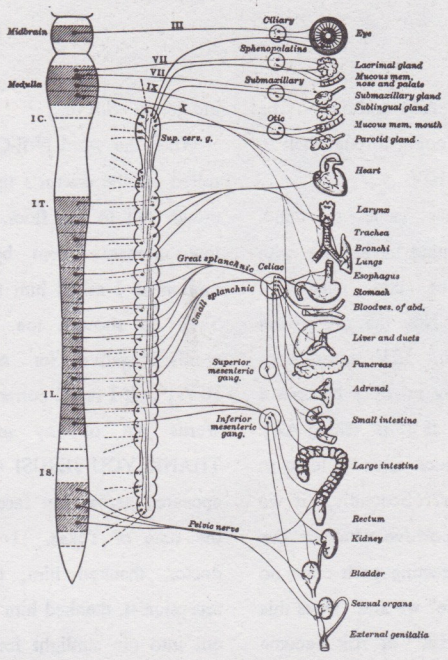
THE CITY OF NEW YORK
OFFICE OF THE MAYOR

AIDS: The Crisis

Be In Good Health

In Memory of John C. Torre

by Dr. Denise Fernandez



Chiropractic is a branch of the healing arts that is based on the premise that good health depends on a normally functioning nervous system. A good state of health exists when body structures such as cells and organs are functioning normally. Abnormal physiology leads to abnormal functioning of the organs predisposing the body to disease.

The purpose of chiropractic in the treatment of AIDS is to help the body regain a balance between structural, chemical and mental facters of which health is comprised. A persons health deteriorates when one or more of the three factors is lost. Through the use of spinal adjustments to telease nerve pressure, nutrition to heop balance the body dhemistry, and muscle therapy to increase blood and oxygen flow to the muscles, chiropractic helps the HIV patient maintain an optimum level of health in order to decrease stress to the immune system.

The brain is the computer of the gody and it sends information to the spinal cord out through the nerves to the muscles and organs to keep the body functioning at an optimum level. Keeping the vertebrae moving freely and keeping the nervous system stress free allows for proper blood and oxygen flow to the muscles and organs. The most important nutrients to the body are oxygen and water. If the muscles or organs are deprived of either of these two substances the body will start to deteriorate. Assisting the patient with the necessary dietary changes helps to reduce stress on the organ systems by increasing the proper utilization of nutrients, and allowing for proper absorption during digestion. Improper diet causes the liver, adrenal and thyroid productivity to slow down. These organs and glands are essential in allowing for proper absorption of nutrients. Improper dietary habits cause stress on different organs which results in irritation to the nerves. The irritation causes a reflex that reaches form the organ to the spinal cord and brain. Therefore causing the entire nervous system to malfunction. Hormones are secreted from the brain which regulate the glands controlling the immune system. There are nerve endings that extend from the brain to the bone marrow, the thymus(major organ of the immune system), the spleen, and the lymph nodes. Conditions that affect these organs are bone marrow deprivation which leads to anemia, leukocytopenia, splenomegaly, and lymphadenopathy, therefore by keeping the nerve energy flowing with proper oxygen supply from the brain to the glands, organs and muscles of the body, and reducing stress on the organs by correcting improper dietary habits; the HIV can help themselves precent further stress to their bodies and maintain a balance in tbe body. Some of the common immunostressors that must be avoided are alcohol, sugar, yeast, caffeine, and saturated fats.

From the time of fertilization the development of the body is based on the intelligence of the brain and nervous system. When we are botm we are provided with the necessary entities to survive, within the body there are well established survival mechanisms designed to maintain a state of good health. It is the responsibility of each individual to maintain his/her own health and the processes taken are different for each individual, because all people are different. The

FALSETTOLAND

by E.K. Washington

Falsettoland, now at the Lucille Lortel Theater on Christohpher street in Greenwich Village, caps off William Finn's trilogy of the "Marvin" musicals. What began, eleven years ago, with a youg Jewish man's "giddy seizures' of sexual awakening with first women, then men, culminates with the wrenching sobriety of the debut of AIDS. The first installment, in 1979, was a show called In Trousers where Marvin who "always gets the things he wants" maticulated from a crush on his teacher, to a highschool sweetheart, to a wife, to a male lover. Two years later i March of the Falsettos, our brat-hero was seen leaving his wife and young son for Whizzer, the lover, while his psychiatrist, Mendel, prepared to take up with Marvin's abandoned Mrs.

falsettoland maintains the same breathless pace of its two predecessors. Set in 1981, the scenario whirls around an imminent bar mitzvah for Jason (Danny Gerard), the son of Marvin (Micheal Rupert) and Trina (Faith Prince) who bicker constantly over its planning. Mendal (Lonny Price) mediates with all the psychotherapeutic avuncularity he can muster and the lesbian couple (Heather MacRae and Janet Metz) next door is full of largesse and culinary ambition. Then Whizzer (Stephen Bogardus), who's been out of the picture, reappears on the scene, reestablishing his relationship with Marvin. He joins teh frenetic ordit around Jason, all of them like planets shot from canons. By the time Whizzer is diagnosed and hospitalized with AIDS, the audience has been caught unawares as to when exactly these planets fell inert, like billiard balls on an abandoned table.

(Continued from page 16)

treatment in chiropractic is based on the individual because everyone is of a different, chemical, mental, and structural composition, the key to good healh and maintainance of the body is strictly by taking preventive measures and by not introducing and foreign substances that furthur surpress the immune system.

Dr. Denise Fernandez practices at 151 East 62nd street in New York City. (212) 753-8785 She started her work with HIV patients in 1987. Dr. Fernandez is a referring Doctor for GMHC, HEAL, And GAY Switchboard.

(Continued from page 12)

There's a long line of consistency to be noted in the Marvin trilogy. Mssrs Rupert and Bogardus are a familiar couple to us from March of the Falsetos. James Lapine, who was director of that show repeats the role here in addition to sharing credit with Mr. Finn for Falsettoland's book. Douglas Stein's sets are, in turn, given a second life. The greatest record of longevity (next to Mr. Finn's) pn this project must otherwise be held by musical director and arranger, Michael Starobin, who was orchestrator and musical director for the original production of In Trousers and Falsettos.

One needn't be either Jewish or gay to relate to or be moved by this show, but being a New Yorker is quite possibly an asset. Falsettoland has the energy of a Midtown rush hour.

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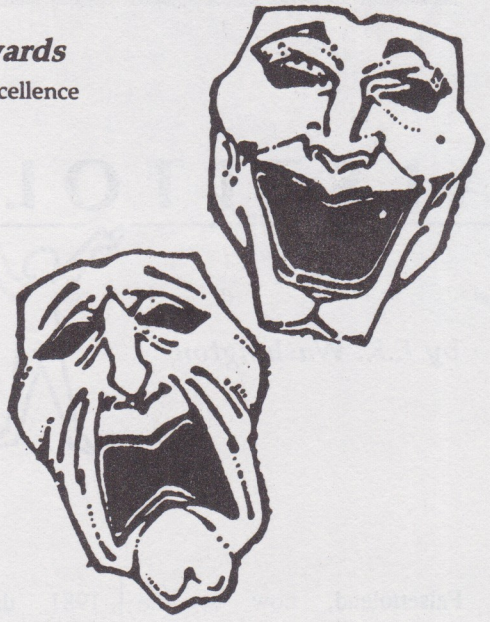

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Managing Your Doctor

by Michelle Roland
AIDS Treatment News

Many patients find themselves dissatisfied with one or more aspects of their relationships with their health care providers. For some, the problem is the amount of time and attention they receive during office appointments or inpatient hospital visits; for other, philosophical differences in treatment approaches leave them feeling misunderstood or unsupported in their decision-making process. Still others find their symptoms undiagnosed and/or untreated for long periods of time.

In this article, we will present some suggestions about how to develop a constructive working relationship between patients and their physicians. In order to do this, we will attempt to explain how doctors are trained to think and how you, as a patient, can assist them in their thought process while having your questions answered to your satisfaction.

What Kind of Patient Are You?

The first step in developing a good relationship with your doctor is to identify the role you wish to play in this relationship. The next step is to find a doctor who feels comfortable working with patients in this way. In order to find such a doctor, you must know what you are looking for.

Many people with HIV infection want to work as full partners with their doctors in managing their health. For such people, frank discussions of diagnostic and treatment possibilities are very important. Others would rather have the doctor do most of the thinking about what could be causing the symptoms and how to treat them without being included in this thought process they would rather play a more passive role and accept the doctor's suggestions without a great deal of interaction.

This distinction is most often not quite as clear cut as it may sound. Many people fall somewhere in the middle, wanting to be included in the decision-making process, but not really wanting to know all of the details along the way. for these patients, brief explanations about what the doctor is looking for will suffice followed with a more in depth discussion of treatment options once a diagnosis has been made.

Determining which role you want to play does not mean that you need to be bound to that role irreversibly. There will be times when you want to know more or less than usual; the challengewill be in identifying those times and being able to communicate your needs to your doctor as they change. Most people, no matter how large a part they want to play in managing their health care, will at times find this role, and the information that comes with it very scary and threatening. The emotional impact of such information should never be minimized, no matter how active you are in your health care.

Finding the Right Doctor for You

In addition to determining how active you want to be in your health care relationship, you need to decide the general philosophical approach you think you will want to take in terms of treatments. Some people feel most comfortable following the standard of care in the medical community. At this time, that would include such suggestions as starting AZ when your T-helper cell count has fallen below 500, and prophylaxis for pneumocystic pneumonia if the count falls below 200, Most often, the standard of care includes FDA approved drugs or treatments for which there is much data supporting safety and effectiveness.

Other people want to try new treatment approaches which have not yet been proven to be effective. Some recent examples of drugs which fall into this

category include compound Q and oral alpha interferon. Some patients want to try new drugs in the context of a clinical trial; others prefer to use them with only their physicians' monitoring and advice. Finding a doctor who is already participating in clinical trials or who is willing to refer you to local trials will be important for patients who want to access potentially effective new treatments in this way. Finding a doctor who is willing to either provide you with largely untested compounds, or monitor you if you want to try this approach. Not all doctors feel comfortable participating in the use of unproven drugs with their patients. It is a good idea to determine your doctor's willingness to monitor and support you in this area if you think you may want to try such a drug now or in the future.

Many people may want to add non-traditional (in the Western medical model) approaches like acupuncture, Chinese herbs, homeopathy, relaxation/visualization, vitamin therapy, etc., to their health care program. Finding a doctor who is supportive of your total health care approach is important in this case. If you want to use both unproven drugs and adjunctive therapies, you should find out how you doctor feels about each of these concepts.

Once you have determined the elements you are looking for in a doctor, you will have to talk about these issues with your current doctor or any new doctor you may be considering. You do have a right to have these conversations with your doctor. Realize, however, that your doctor may not be used to having this kind of discussion, your doctor might be more open if you tell him or her that you want to talk about philosophy and style and arrange a time to have his discussion; this approach will allow the doctor to schedule the necessary time and prepare to switch gears from the purely medical issues with which she or he may be more comfortable to a frank discussion of partnership.

[Note that this article assumes that the patient has a high degree of privilege and accessibility to a variety of doctors from which to choose. The unfortunate reality is that in many of the public health and HMO systems, and in many geographical locations, the patient's ability to choose doctors is very limited. In such cases some of the later suggestions in this article may still be useful, although more difficult to implement.]

How Do Doctors Think?

Doctors are trained to think in four main steps. Understanding this thought process can help you learn how to ask questions in a way that will help your doctor think better and provide you with answers to your questions.

First, the doctor takes a history, or asks questions about your current complaint and pertinent aspects of your past medical history. At this time, the doctor tends not to examine you, but rather just to talk. This may seem a little awkward, as you may want to show the doctor what it is you ar describing. He or she will probably ask you to show where your discomfort is, but will not focus on the physical exam until after asking you as many questions as he or she can think of.

This may be an area where people feel cut short or ignored. The doctor is again working with conflicting needs: the need to listen to you and let you talk and the need to keep on schedule. You can help by trying to answer the doctor's questions completely but to the point, and the doctor can help by being attentive to you. Doctors are told all throughout their training that the majority of information they need to make a diagnosis will come from the history, so they should listen well.

You can also help in this area by reminding the doctor of important facts of which they may have lost track, like weight loss over an extended period of time, recent and past medication changes, adverse reactions to medications, visits to other doctors, recent lab tests or x-rays that have been ordered, etc.

Next, the doctor does a physical exam based on the information from the history. Again, this may seem awkward, because the doctor's thought process has shifted; he or she may not want to talk much while examining you. Some doctors will be able to put you more at ease during the physical by keeping up the conversation. Others may concentrate intently on the exam.

Once the doctor has collected the data from the history and physical, he or she makes an assessment, which should take the form of a differential diagnosis. This is the stage where he or she considers all the possible causes for your symptoms and physical signs found during the physical exam.

Finally, the doctor decides on a plan to determine which of the possible diagnosis is the correct one and how you should be treated.

You can play a crucial role in the last two stages: trying to figure out what is causing the problem and deciding how to treat the problem. This is the thinking that the doctor usually does in his or her own head, or while writing in your chart. If you want to be involved in the process, these are the kinds of questions you can ask: What are the possible diagnoses you are considering to explain my symptoms and physical findings? What makes you consider each of these possibilities? Is there anything else we should be considering? How will we figure out which of these possible diagnoses is the correct one? What tests should we run? How invasive is each test? How expensive? How accurate? Are there some tests we should run more than once (stool samples for ova and parasites, for

example)? What ar the risks and benefits of each test? In what order should we do these tests? What treatments should I consider at each stage - before we have a diagnosis, and after we have it figured out?

The most important thing you can do to help your doctor think through the problem and help you feel assured that you are getting the best possible care is to map out a plan with the doctor. What will you do first? If you cannot make a diagnosis after doing that, then what will you do? Then what? Then what? You can go through the same process with treatment possibilities once a diagnosis has been made. What are my treatment options? If I try this and it doesn't work, or the side effects are too bad, then what could I try? Then what? Are there any other medications I can take with the treatment that might make the side effects more tolerable? What side effects should I expect?

Following Up

Chances are that you will still have questions when you leave the doctor's office or later as you think about all the information you have received. Write your questions and concerns down and bring them with you to your next appointment.

Working with an assertive patient can be threatening to even the most enlightened doctor. To soften the "threat", try to validate your doctor and to take his or her needs into consideration. Find something you like about what the doctor is doing before you jump into all your questions and concerns. Tell him or her that you'd like to talk about several issues and that you are aware there may not be time to cover all of them during this appointment. Ask how much time you do have, and if you can schedule another appointment soon to discuss the issues which are not highest priority. Make sure you know what your priorities are so you can have as many of your needs met as possible during each appointment.

Finally, ask yourself what questions you always seem to have after an appointment. What consistently frustrates you? Try to take those questions and frustrations and figure out how to talk to your doctor about them so that you can decide together how best to take care of all the parts of you.

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exercised. Triceps, quadriceps and hamstrings are exercised Tuesday. On Wednesday, back, shoulders and abdominals are exercised. And Thusday is a rest day. Monday's exercises are repeated Friday, Tuesday's exercises are repeated Saturday, etc..

The final type of exercise is bodybuilding. Bodybuilding is similar to strength training in that you execute multiple sets of exercises for each bodypart, use a three to six day rotation routine and exercise different bodyparts on different days. Bodybuilding differs however in that its purpose is to sculpt the body. Muscles are worked with different intensities to shape bodyparts to a desired point. A moderate amount of weights are used (75 to 80% of max.) with a moderate to high number of repetitions (8-12). The rest period should not exceed one minute allowing the muscle to become completely exhausted by the end of the last set.

Being that fairly heavy weights are used when employing strength training and bodybuilding, it is advisable that you have a training partner or utilize a spotter, someone to observe each repetition and assist with the weight if necessary. Every repetition should be executed with strict form and total concentration directed towards the muscle being exercised.

Different types of exercise offer different types of improvement for the body. So it is advisable that you incorporate different types of training in your daily routine and continually re-evaluate your program, making appropriate changes.

With any type of exercise we must remain tuned into our bodies so that we are aware of pain, fatigue or overtraining. Overtraining, doing too much exercise, causes stress, depression and pain in the muscles and joints leading to a weakening of the immune system.

Proper rest is as important as every repetition that is completed during exercise. Some portion of each day should be set aside and reserved exclusively for ourselves. A time when our minds are allowed to float free. Sit in a hot tub, take a leisurely walk or engage in a hobby.

Meditation also is a good way to relax. Not only does it help us to tune into ourselves, it also causes a realease of endorphins in the body. Endorphins are a natural chemical that when released in the body cause a heightened physical and emotinal state. These are the same endorphins that are released in the body along with noradrenaline during exercise. Noradrenaline is a mood enhancer and is often used in the treatment of depression. This explains why some people actually become addicted to exercise.

Of equal importance in our daily routines is diet and nutritional supplementation. It is a medical fact that a proper nutritional program does much to support the immune system. Although maintaining a proper diet low in fact, cholesterol, sodium and caffeine, and high in protein, fiber and natural carbohydrates is necessary to provide the energy needed to get us through our daily routines, it may not be enough. With the way food is processed and packeaged today, we cannot always be sure that we are getting adequate nutrition from our meals. Vitamin and mineral supplementation is a way to ensure that our bodies receive the proper nutrition needed to stay healthy.

Like the rest of our body the immune system utilizes vitamins, minerals and amino acids. Specific vitamins, minerals and amino acids have a very beneficial effect on the immune system. Vitamin C stimulates the most important T & B cells and improves mobility of white blood cells. Vitamin E bolsters the production of antibodies. Deficiencies of vitamin E lowers levels of T & B cells. Zinc is a very important meneral for the immune system in that a deficiency of zinc may cause shrinkage of the thymus gland. Major production of T cells takes place in the thymus gland. The amino acid lysine assist teh immune system by forming antibodies that fight invading bacteria and viruses. These are just a few of many vitamins, minerals and amino acids that directly effect the immune system. For suggestions on appropriate supplementation a Physician or Nutritionist should be consulted.

Since manifestations of illness are our bodies way of telling us that we are not trating it right, we must constantly monitor ourselves, listen to our bodies. Exercise is meant to reduce stress and promote health and well-being. So that on any given day, the idea of exercising causes anxiety or you are feeling over- ly tired, skip the exercise for that day and engage in an activity that you find relaxing.

Engaging in regular, proper exercise while continually monitoring our internal environment will help us to maintain a sense of well being. This sense of well being will promote health and also help us to achieve greater sucesses in all aspects of our lives.

M. Mike Wade is president and founder of Body Maintenance, One on One Fitness Instruction, Massage and Nutritional Counseling.(212)629-2081

(Continued from page 6)

drugs are modifications of natural enzymes in the cell that the virus relies on to put finishing touches on its own proteins. One of these enzymes prunes back a viral protein, enabling it to bind to CD4 when the virus infects a new cell. If this enzyme is blocked the virus particles are not infectious.

The other enzyme adds a chemical tag to the viral proteins. Without this tag, the virus particles cannot assemble inside the cell to make new viruses.

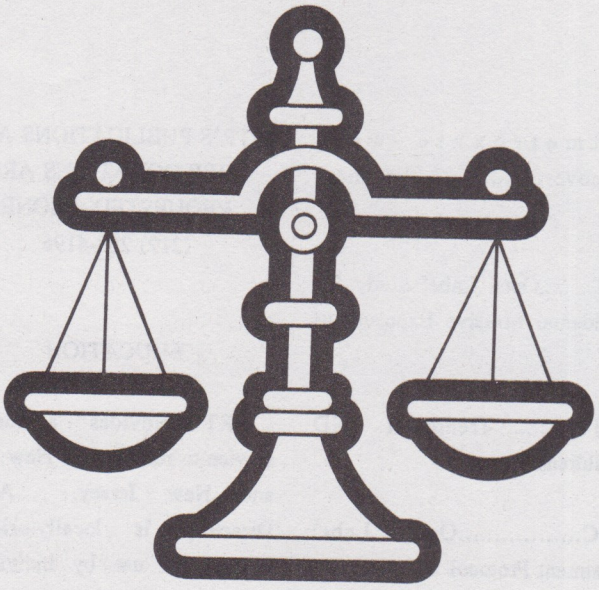
Dr. Broder and others expect that the drugs found so far are just a beginning. And although there is a long way to go before AIDS becomes a manageable disease, the accumulating wealth of intimate knowledge about the virus is seen by Dr. Broder as reason for great hope. "Our optimism is based on reality," he said.

Gina Kolata is the New York Times specialist on AIDS. Copyright @ 1990 by The New York Times Company. Reprinted by permission.

AIDS Treatment Resources, Inc.

Providing Comprehensive Information on Experimental AIDS and HIV drugs being tested in Clinical Trials.

by Tony Davis



AIDS Treatment Resources, Inc. (ATR), is a non-profit, community based educational organization, providing comprehensive information on experimental AIDS and HIV drugs being tested in clinical trials in New York and New Jersey to all members of the communities affected by the epidemic. ATR strives to provide clear and readable information on trials and treatment options so that people with AIDS or HIV may easily locate the study which is most appropriate for them and learn what is required to participate.

In late 1987, the Treatment and Data Committee of the AIDS Coalition To Unleash Power (ACT UP) began to collect information on AIDS/HIV clinical drug trials and soon identified several serious problems in the U.S. drug evaluation and approval system. Recognizing the need to create an autonomous mechanism to address these problems, twelve members founded ATR and began meeting weekly in January 1988. ATR was incorporated as a New York not-for-profit organization in October 1988.

Nationwide statistics from The National Institute of Allergy and Infectious Diseases (NIAID) on the government-sponsored AIDS Clinical Trials Group (ACTG) Program document the underrepresentation of Blacks (9%) and Hispanics (11%), women (5%), and intravenous drug users (11%). The figures are even more dramatic in New York City, considering that Blacks and Latinos represent the majority of diagnosed AIDS cases. There are over 1,000 women with AIDS, the majority Black or Latina. Meanwhile, at least 60% of New York State's 260,000 I.V. drug users are HIV-antibody positive, and the majority live in New York City. Yet patient enrollment in New York City drug trials for AIDS is largely white (65%), male (87%), non-I.V. users (85%).

African-Americans and Latinos, women, children, intravenous drug users, and the poor are often excluded from clinical trials due to little or no awareness that such trials exist. In addition, traditional recruitment/referral patterns favor patients with private physicians and private health coverage, versus disenfranchised individuals requiring a variety of non-medical support services. Finally, minorities and women often lack basic primary health care. Yet, experimental drugs to treat AIDS? HIV may represent not only promising therapies, but the only treatment option available.

Clinical trials fall into seven basic categories:

1. Anti-HIV Treatments (Drugs that may fight HIV)
2. Immune Boosters & Other Drugs(Drugs that may help the immune system or help the body in other ways. Also see Vaccines)
3. HIV-related infections (Drugs that may treat or prevent opportunistic infections)
4. Cancer Treatments (Drugs that treat AIDS-related cancers)
5. Vaccines (Drugs that may treat or prevent HIV infection)
6. Mental Health Treatments
7. Trials for Children

For those ineligible or too sick to participate in clinical studies, the Directory also lists drugs available outside clinical trials. Below is a list of drugs available through Treatment IND and Compassionate Use. No one should be asked to pay for any of these drugs. Several of these programs are specifically set up for individuals who cannot afford them:

Diclazuril....Compassionate Use

EPO(Erythropoitan)..Treatment IND

Fluconazole.....Compassionate Use
Foscarnet.....Compassionate Use
GMCSF.....Compassionate Use

Spiramycin....Compassionate Use

Trimetrexate with Leucovorin.....Treatment IND

AZT.....Open Label Study for Accidental Massive Exposure to HIV

AZT.....Treatment IND (Children)

DDC.....Open Label Treatment Protocol

DDI....Treatment IND and Open Label Protocol

DDI...Open Label Treatment Protocol (Children)

FREE PUBLICATIONS

In order to get treatment information to all who need it, ATR publishes and distributes the Directory of AIDS Clinical Trials-New York and New Jersey (updated quarterly) and Deciding To Enter an AIDS/HIV Drug Trial, an educational guide for prospective trial participants (also available in Spanish and Creole). Should I Join an HIV/AIDS Clinical Drug Trial? (English/Spanish) is an easy-to-read introduction to individuals interested in experimental treatments for AIDS/HIV.

The October-December 1990 edition of the Directory presents detailed information on 69 trials of 52 drugs underway at 45 hospitals in New York and New Jersey.

ATR'S PUBLICATIONS ARE FREE-DONATIONS ARE REQUESTED, PHONE (212) 268-4196

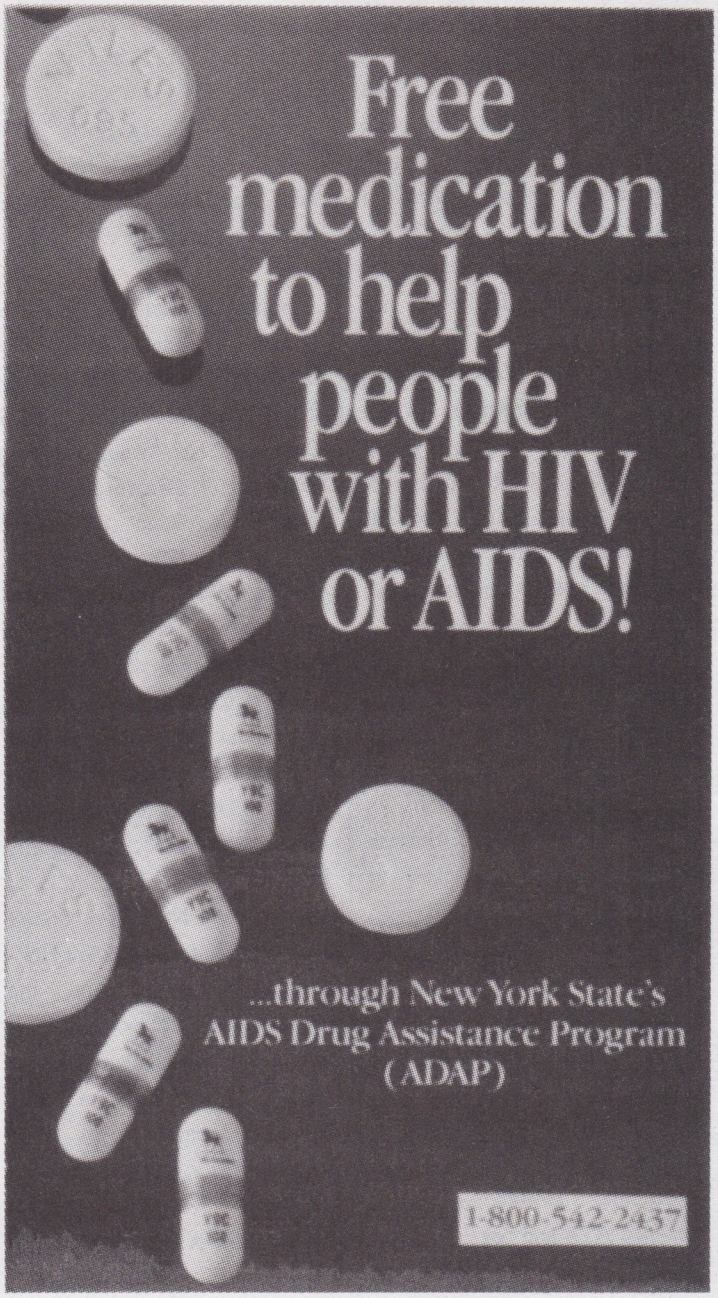
EDUCATION

ART provides a unique service to residents of New York and New Jersey. ATR's Directory is locally-oriented written for use by individuals with Aids of HIV illness as well as AIDS service providers. Without sacrificing the scientific quality of information, ATR's goal is to make the Directory as simple and easy-to-use for both lay persons and medical professionals. The Directory includes a comprehensive glossary of medical terms, and a section explaining the structure and aims of the clinical trials for potential participants. In short, ATR's emphasis in on patient and community empowerment. The local focus makes ATR's listings more comprehensive than AmFAR's AIDS/HIV Experimental Treatment Directory, and allows for direct interaction with users of ATR's Directory. Office staff frequently act as advocates to help people get experimental therapies.

OUTREACH

ATR regularly conducts Workshops for people with AIDS or Hiv, and is now expanding its program of Seminars and Training for health care professionals, including social workers. In addition ATR is forming six community Outreach Working Groups. These groups will assist ATR in developing and evaluating outreach strategies and materials for African-Americans, Latinos, women, intravenous drug users, prisoners and those responsible for children with AIDS or HIV illness.

BG Magazine Encourages you to VOLUNTEER!



testing experience, most of the men who had been tested reported that knowing their test results was something that helped them, though those men who were HIV infected and symptomatic, understandably, were more likely to be depressed than those who were not experiencing symptoms.

For those men who did not know their HIV antibody status, we asked them to rate several possible reasons why they had not been tested. Two Primary reasons given were that they felt they would not be able to handle knowing if they were HIV antibody positive and concerned about being discriminated against.

In a time when early detection of HIV infection is an important factor in early medical intervention to slow progress of the disease, it is important to know that many men avoid testing out of concerns about its emotional impact. We also cannot ignore those African-American men whose concerns over discrimination are very real and have served as barriers for their getting tested.

In the early years of the epidemic the White gay community advocated and received anonymous test sites. Many found out about their test status in situations with little risk of legal ramifications. However, for African-American gay men who want to know their HIV status now, the current public health emphasis is less on anonymous and more increasingly confidential testing.

While we fight for the necessary resources in our efforts toward behavior change and HIV risk reduction in African-American communities, we must not forget the importance of political interventions to help us in changing behaviors. Continued access to anonymous testing sites, as well as strong enforceable laws prohibiting discrimination for those with AIDS, HIV infection or thought to be HIV infected, is important in increasing the numbers of African-American gay and non-gay identified men who will get tested.

BLACK C.A.R.E. is still accepting questionnaires to meet our goal of hearing from 1,000 of you. Many of you received our lunar blue letters and questionnaires. If you haven't completed our questionnaire please do so as you can see your opinions can help other African-American men in our community.

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Early Intervention

Black Gay and Non Gay-Identified Men's Reasons for Not Having HIV Antibody Test

	Gay Identified			Not Gay Identified		
	Not Important	A Little Important	Very Important	Not Important	A Little Important	Very Important
Feels he couldn't handl e Positive Results	25%	31%	44%	42%	24%	34%
Afraid he might get discriminated against	57%	19%	24%	49%	11%	40%

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RESOURCE DIRECTORY

African American Wimmin United for Societal Change(AAWUSC), a 15-year old organization serving lesbian wimmin of color. *Meetings* Thursdays, 8 pm*, $3 PO Box 1119, NYC 10009

Anti-Violence Project, 807-6761. Hotline:807-0197

Asian Lesbians of the East Coast (ALOEC), *business meetings*,1st weekend, 3pm*. *Socials/dinner*, last Friday 6:30 pm. *Discussion group*, alternate Sundays*, Info: 517-5598. PO Box 850, NYC 10002.

Bronx Lesbians United in Sisterhood (BLUeS) Social/political, meetings–1st &3rd Fri. 6:30-8pm*, 829-9817/409-1131. PO Box 1244, Bronx, NY 10462

Brooklyn Women's Marital Arts, Self-defense, Karate, & Tai Chi classes, 421 5th Ave, Bklyn, NY, 718-788-1775

Brooklyn Task Force on Aids, 718-596-4781.

Gay Men of African Descent (GMAD), *meetings* Fri.*, 80 Varick St., NYC 10013, 718/802-0162.

Gay Men Health Crisis, Hotline: 807-6655

Hispanic United Gays & Lesbians(HUGL), *meetings* 8pm, 4th Thursday*, 201/653-7824, PO Box 226, Canal St. Station, NYC, 10019.

Las Buenas Amigas, support group for Latina Lesbians. *Meetings* 6/3 & 6/17, 1-3pm*, 477-1527/316-2217 or 201/866-1427.

MAMA DOESNT KNOW! Productions, Positive images of Lesbians & Gays of Color through the Arts 208 W. 13th, NYC 10011, 245-6366

Men of All Colors Together (MACT), A multi-racial group of gay men aginst racism. *Meetings* Fridays, 7:45*, 245-6366/222-9794

Minority Task Force on Aids, 749-2816.

Multi-Cultural Committee (MCC) Plans events for people of color/participation in Center Kids by all racial & ethnic groups. Doug 923-1976, Sara 718/965-3795

National Coalition for Black Lesbians and Gays, NY Chapter, (NCBLG) PO Box 1399 NYC 10026 718 622-3576

North Star Fund funds/supports progressive community organizations. 666 Broadway, 5th fl, NYC 10012, Betty Kapetanakis, 212/460-5511.

NY Black Women's Health Project support groups & community education about health, wellbeing & power, PO Box 401037, Bklyn, NY 11240 718/596-6000.

Other Countries/Black Gay Men Writing, Meetings, Sat. *, PO Box 3142, NYC 10008, 505-0506

Parents of Color & Our Families, a social & support group For info/meetings: 718/633-3496.

People of Color in Crisis, AIDS support group, 718/596-7979.

Project Reach, Asian Community Organization, 1 Orchard St., NYC, 10002, 807-7517

Stations Collective, 155 Lafayette Avenue, Bklyn, NY, 11205 Cheryl Taylor, 718/596-4389 or 693-9686.

*The Lesbian & Gay Community Services Center, 208 West 13th, NYC, 10011 212/620-7310. $2 donation to the Center unless otherwise specified.

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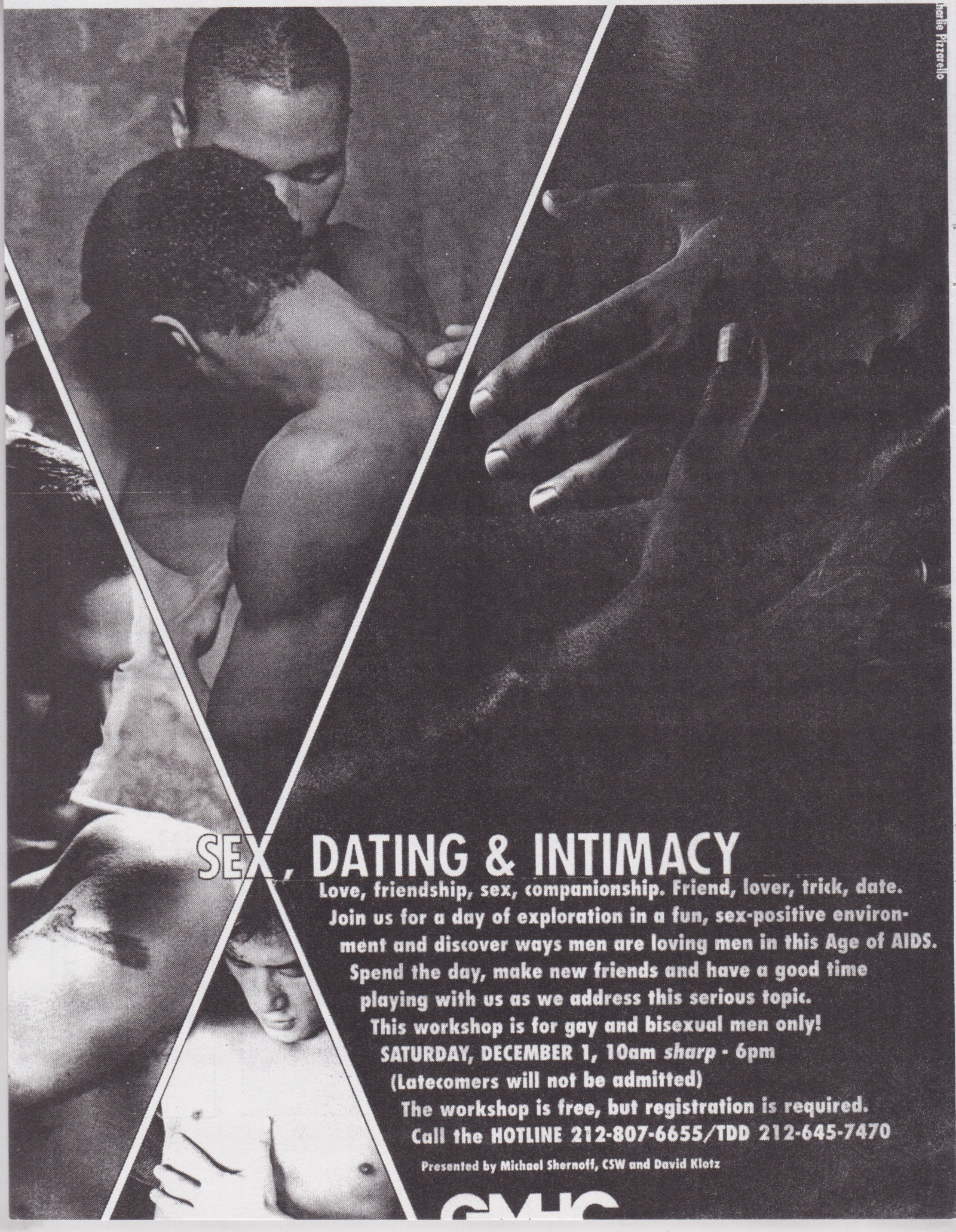
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RECEPTIONIST/CLERICAL ASST.

The NYCG&L Anti-Violence Project, a non-profit crime victim services agency working with lesbian and gay survivors of bias-assault, domestic violence etc. seeks candidates, 45wpm, computer exp. Mon-Thurs 12-8pm Fri 10am-6pm. Letter and resume to AVP, 208 West 13th St. NYC 10011.

BG SALES EXECUTIVE

Magazine sks aggressive salesperson who wants to control own work hours and earnings. Exp. pref. but will train right person. Top commission pd. Resume to BG Magazine, Cooper Staion, Box 1511, NYC, NY 10276 Attn: J. Cornell.

WRITERS

EDITOR

Managing Editor needed to coordinate all phases of OtherCountries: Black Gay Voices second journal publication. 212-505-0506.

WRITERS, ARTISTS, PHOTOGRAPHERS

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DECEMBER:
Our Families

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MEN OF COLOR AIDS PREVENTION PROJECT (MOCA)

MOCA, an AIDS prevention program targeting gay, bisexual and non-identified men of color, is expanding its outreach and education activities. Immediate openings include:

ASSISTANT PROJECT COORDINATOR (AIDS Education and Outreach): Supervise outreach staff, coordinate other educational activities; assist in the management of contracts for these services; evaluate direct and contract services. BA/BS and 2 years of public health education experience, including 6 months in AIDS prevention required; MPH preferred. Salary range: $30,262 - $34,861.

AIDS PREVENTION COUNSELORS (P/T): Conduct evening and weekend outreach sessions and educational programs in bars, baths, cruising areas, etc.; counsel gay/bisexual men of color on safer sex, and access to services. HS diploma and 3 years of community work experience required. Salary: $11.87 per hour.

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Send resume, indicating position(s) of interest, to: Irma Mojica
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MEN OF COLOR: AN ESSAY ON THE BLACK MALE COUPLE is the first comprehensive collection of literary and visual work to explore the black male couple with prose, illustrations, and photographs.

Strong graphic images, and sensual photography emphasize both the strength and love necessary for a black male couple to survive. This book attempts to provide positive images of black gay males, which express the sensual and romantic side of two individuals, who are men of color, men in love.

NEW YORK

Hot Italian-Latino wants hot,hung,muscular,-bubble butt black or latino. I'm 5'9",150, built, hung and chill. Send photo,phone to J.C.,-POB 1227,NYC 10018

GBM, 28,bottom,seeks hung BM, POB 2439 NYC 10108-2030

SBDM,40,kinky artist likes submissive gay, bi-women,black or white healthy, friendly,kind,no drugs,excessive drinkers,phonies,b.s. 23+ that like a dominant man. ph/phone. H5050

GBM, 24, 6'5", 260lbs, music student, sks GBM or GPRM for friendship & ultimately a relationship. Please be intelligent, goal-oriented & preferably conservative tall a +,24-28. JMJ, P.O. Box 648, NYNY 10023.

WM 32, 6'1", 185lbs into sports, workouts seeks similar BM. P.O. Box 1172, Flushing NY 11354

GWM, 32, 6'1", 170. Looks and brains. Arts, politics, baseball, the offbeat. P.O. Box 1005, NYC 10009.

GJM, 40, 5'10", 155 lbs, cute blue eyes and wise, desires masculine GB top man, 30 and older. Sensitive and mature to explore whose are. Foto/phone if possible. P.O. Box 20, NYC, 10012.

Erudite passive stallions turn on this very hot BM (6',175 lbs.,30s) looking for stimulating encounters with horny smartasses. P.O. Box 786, New York, NY 10026.

NEED A LOVER

GBM, 40 yrs old 5'9", 180lbs who is looking for a lover, companionship and a happy relationship, who do not smoke, rarely drinks, work hard in our relationship, love our gay community, I am honest to my lover, aggressive. It has to be one BM in the city of NY who enjoys the same, no druggies, or fat, love safe sex. Would like to meet a BM who enjoy the same, age 30 to 45 years old. Please respond with letter and photo. F1677.

AAGMAD seeks warm, dimpled, articulate, AIDS-aware, dread named Winston. 212-337-3556.

GBM 23, handsome, swimmer's physique, 170lbs, 5'11", seeks well-endowed, virile, dark-skinned BM, 18-30 for fun erotic relationship. Please send photo/letter and/or phone. F2688

Hispanic/Italian

Hot and sultry 19 yo Hispanic/Italian GM, 6', 150lbs., with Uomo Vogue beauty, fun to be with. I want to meet young GMs to go out to movies,theatre, concerts, dinners and more! Photo/phone to: P.O. Box 570, NYC 11004.

Blue eyed GWM in NYC seeks hot, young, masculine attractive clean shaven, latin, Hispanic, Black for friendship or more. I'm handsome, 34, 5'9", 150lbs, clean-shaven, into SS, BB, music, art, travel, send PH/PH to Roger. E6263.

Searching for that special person! WM looking for relationship, 39, 6'1", 160lbs, clean, clean shaven, brown eyes, brown hair some gray. E6490

GBM 5',7", 155lbs, lean, seeks GM bottom 18-25, slim or medium build w/ bubble bottom for good times. I enjoy movies, sports, walks etc. Drug free and HIV negative. Write w/phone & Photo to: J. Scott, 217 East 86th St., Ste. 205, NY, NY 10028.

GBM, 36, 6',190lbs, attractive, literate, professional seeks similar, GB/H, masculine man to settle down. E6126.

GBM MINIMUSCLES

I'm a GM, 40s, 5'9", 145lbs, trim and athletic, looking for a small framed muscular, athletic GBM topman and companion, age 20-40. E4656.

6', 190lbs, 42 Y.O. In search of muscular BG. B1124.

Digs hi-iq GB or W, studious, stable, kind; into Liberal Arts, smiling & safe loving! Earl at 212-866-2262.

SENSUOUS GWM

Mature, 6', literary interests, user friendly. POB 387, NYC 10011.

SENSE OF HUMOR

GWM, 5',10", 160lbs, brn/blue, 36, sks intelligent. culturally aware GBM w/sense of humor. I like dancing, exercise, reading, arts. Write David, POB 291, NYC 10011.

GBM, 34, 6',1", 178lbs, muscular, seeks other GBM who are intel & enjoys METS games as well as good conversation. D1224.

BLACK MALE WANTED

25-40, by very attr., hlthy WM w/bl-gr, 31, 6'1", 185lbs. I am ultimately seeking perm relat w/masc top man but would always welcome new friendships. All sincere apply. C7600.

GBM, 30, 5',11", 260lbs, br/bl, big hairy tits. Gr & Fr a/p sks BG bb. C8132.

NEW YORK PUERTO RICAN

PR/Italian, seeks BGM top for gr/fr. Ph/ph: Box 118, NYC 10014.

CHILL HOMEBOY

GBM 24, 5',9", 147lbs, handsome, very discreet, seeks butch to bang; type: GBMs, 18-27, who are chill, fun-minded & sexually challenging for companionship. Please send ltr-/photo/tel. D8996.

BIG DADDY TOP

GBM 40, 5'11", 205lbs., sks a Big Daddy Top. No drugs, smkrs. Stach A+. Race unimport. I am fun, exciting, high standards & unique. Sense of humor a must! POB 4000-73, Bklyn NY 11240-0073.

NEW JERSEY

GWM, 38 yrs., 5',8", beard. D9267

GWM, athletic, would like to meet gay, straight or bisexual BM for friendship, etc. Must be straight acting, athletic, 18-35. South Jersey area. Write: Nick. B1157.

DEDICATED

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BLACK MAN ONLY

GWM, 5'5", 128lbs, slender build, would like to meet a masculine black man for a 1-on-1 perm. relationship. I like quiet evenings, dinner for two, TV & good times. Opposites attract. Call Frankie 609-547-5878.

Men of All Races sought by in-shape GWM, 5'8", 145lbs,bi/bl 40. D0909

PENNSYLVANIA

Top GBM 23, attractive, swimmer's build, seeks fun times & friendship w/sincere, intel. mature men. D2221.

GBM, slim, 40s, sks j/o buddies to share sex & other interest. Prefer slim males of any race for mutual good times. D5786.

GWM, 40 sks any race or color for intimate joining. I do it all. D6799.

34, 5'11", 165lbs, attr., str. acting, desires in shape attract. GM, 29-40 who is sensitive, has sense of humor, enjoys old movies (like "All This and Heaven Too"), walks in the park. Take a chance, let's get together. C4780.

Submissive black male, wanted by black (suburban) male for live-in, daily, safe penetrating action. 18-40 (215) 698-8525 (Reggie)

PROFESSIONAL BM

52 yrs. old, tall, attr.,str. acting, would like to meet GM, 40-55 for friendship, sharing, intimacy which hopefully will lead to monog. relationship. Reply: C4578.

BUSY GWM

Exec., 30s, looking for GBM, 20s, in shape, hard body for special times. Mutually beneficial. Phone/photo returned. C5321.

BLACK DAD WANTED

GWM, 35, looking for GBM, 40-45 to be my dad and spank me in a monogamous lover relationship & live together. I am very loving and romantic. Reply: C6472.

TEXAS

SAN ANTONIO, 38 Y.O.

Rd/bl, 6', 170LBS. Non-smkr/drug user, seeks boomer for sparky convers., cafe noir & moonlight, snug 501s, etc. Race, wealth, super gd lks unimport, but IQ a plus. C8095.

VIRGINIA

GBM, 20s

Would like to meet GWM for friendship & poss. relationship. D8233.

Top GWM, 56, 5'9", 165, straight acting, stable, secure, non-smoker, non-drinker, seeks younger career oriented GBM for a possible long-term warm and loving relationship. Photo appreciated. P.O. Box 23093, Alex., VA 22304

OREGON

BIWM

Str. acting, athletic, 39, seeks men 20 to 40 of any race that are athletic, masc. discreet for recreation. Leather OK. C7302.

MARYLAND

Safe top GBM, 38, 5'4 1/2", 125lbs, muscu, dancer. Seeks hot, clean shaven/mustache, HIV neg, BM, Latin, Hispanic, Italian, Greek, 28-45. GR+FR, Non-smoker, non-drinker, no drugs, totally submissive bottom w/small muscular build. F0499.

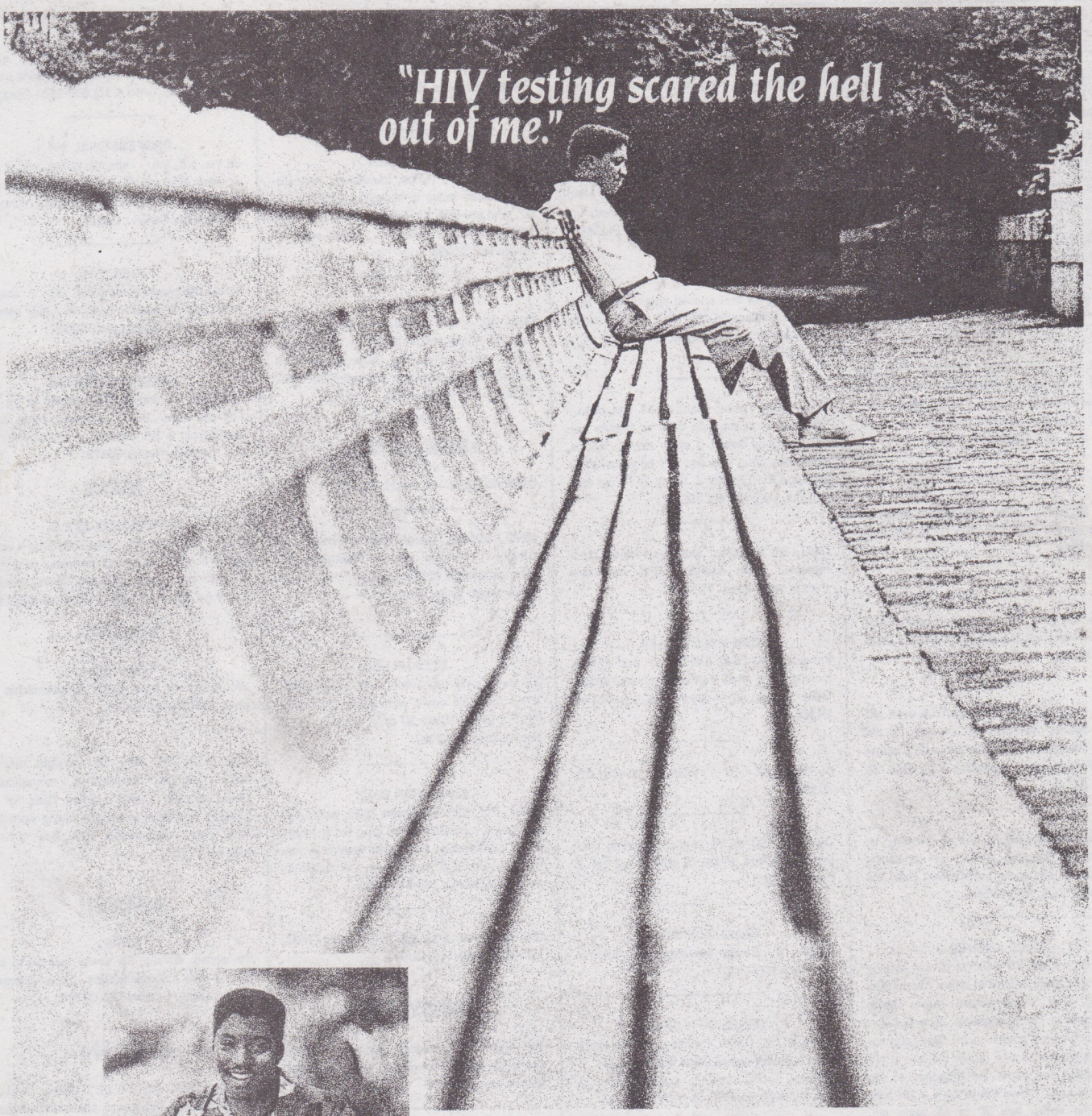
MASSACHUSETTS

BOSTON BGM

GBM seeks Nubile Nubian for loving man to man relationship. Spandex buddies encourage. Joe Simmons, Ty Jones, Tony Wallace, Kevin Thomas. Call Paul: 617-427-9401. Late night or lv message.

CONNECTICUT

Tired of children, the boys. Handsome black prince needs a real black man, 35+. C9710.



"I found out knowing is better than not knowing." Every day, more and more people are learning to live with HIV. People are finding ways to stay healthier, strengthen their immune systems, develop positive attitudes. They've found that proper diet, moderate exercise, even stress management can help. And now, early medical intervention could put time on your side.

Today, HIV positive doesn't mean you have to give up. So, the sooner you take control, the better.

For more information on living with HIV, we urge you to call the number below... anonymously, if you wish.

LIVING WITH HIV.

1-800-HIV-INFO THE SOONER YOU TAKE CONTROL THE BETTER.

Brought to you as a public service by the Association for Drug Abuse Prevention and Treatment, Bronx AIDS Community Service Project, F.A.I.T.H. Services, New Jersey Buddies, New Jersey Women and AIDS Network, Newark Community Health Centers; and American Academy of Dermatology, American College of General Practitioners in Osteopathic Medicine and Surgery, American Osteopathic Association, American Social Health Association, National Association of People with AIDS; and Burroughs Wellcome Co.